

SB 251
TASK FORCE TO STUDY ELECTRONIC HEALTH RECORDS

June 12, 2006
MINUTES

Task Force Members in Attendance √, Absent x, Representative *:

x Thomas Allen	√ David Gens	√ Victor Plavner
x Stephanie Amey	√ Mary Hendler	√ Jack Schwartz
√ Peter Basch	x* Paula Hollinger	√ Kevin Sexton
√ Beverly Collins	√ Aubrey Knight	√ Dorothy Snow
√ Barbara Cook	x* Carey Leverett	√ Angelo Voxakis
√ Rex Cowdry	x*Thomas Lewis	√ James Wieland
x* Jimmie Drummond	√ Gina McKnight-Smith	x Ken Yale
√ Michael Flores	x* Susan Newbold	
√ Paul Fowler	x* Shane Pendergrass	

- * Chris Gibbons for Jimmie Drummond
- * Steve Mandell for Paula Hollinger
- * Shereen Martin for Carey Leverett
- * Erin Grace for Thomas Lewis
- * Brenda Cunningham for Susan Newbold
- * Erin Hopwood for Shane Pendergrass

I. Meeting Call to Order

Task Force Chairman Peter Basch, M.D. called the meeting to order at 2:05 p.m.

Dr. Basch welcomed the members of the Task Force and the public to the meeting. He announced that with the passage of HR 4157, a significant expansion of federal involvement in health information technology (HIT or health IT) is under consideration; however, the bill authorizes a relatively small amount of money that is narrowly focused. Chairman Basch observed that the theft of 26.5 million Veterans Administration records would focus concentrated attention on health IT issues. On behalf of the Task Force, Chairman Basch congratulated Task Force member Delegate Shane Pendergrass, who, with Dr. Carolyn Clancy, director of the Agency for Healthcare Research and Quality (AHRQ), has recently received this year's Advocacy Award from HIMSS (the Healthcare Information Management Systems Society.)

II. Approval of the Minutes

Aubrey Knight made a motion to approve the Minutes of the May 8, 2006 Task Force meeting, which was seconded by Beverly Collins, and unanimously approved.

III. **Presentation and Discussion — Maryland State Department of Education, Confidentiality and Privacy of School Health Information**

Donna Mazyck, from the School Health Services division of the Maryland State Department of Education, presented information to the Task Force on the confidentiality and privacy requirements that cover school health records. The potential impact of an expansion of the use of electronic health records on the paper-based record system maintained on students by both the regular level of school health services and by the 61 school-based health centers across the State is an area of inquiry specified in the Task Force's enabling legislation.

Ms. Mazyck explained that all records belonging to a student are considered to be a single, confidential record, including cumulative health, psychology, and special education components. Student health records are considered to be "educational records," and as such are governed by the Family Educational Rights and Privacy Act (FERPA), which:

- Requires confidentiality of educational records;
- Allows parents to access all of their children's education records;
- Does not defer to state laws regarding minor consent; and
- Protects the privacy of education records in schools receiving federal funds, thereby exempting these records from HIPAA privacy rules.

Because FERPA rules apply only to schools receiving federal funds, some school systems may have individual schools where FERPA does not protect the confidentiality of health records; in those cases, HIPAA rules would permit disclosure of protected health information "with a valid authorization."

She noted that minors in the state of Maryland have the legal right to consent to treatment for and/or advice about alcoholism and drug abuse, sexually-transmitted infections, pregnancy, and contraception (although not sterilization.) They may consent to a physical examination and treatment for injuries from alleged rape or sexual offense, and an initial medical screening or physical exam on (and after) admission into a detention center.

Under Maryland law, student health records must be kept until the student reaches age 21. The entire health record is sent with a student who transfers to another school. With regard to the record of immunizations required for children to enter school in Maryland, HIPAA does not specifically address the disclosure of immunization information, though it does permit the disclosure of protected health information by a public health authority for certain purposes, such as prevention/control of disease or injury; disclosure of "vital events" such as birth and death; exposure to communicable diseases; and reporting of child abuse or neglect. School nurses are being trained to have viewing privileges on IMMUNET, the DHMH electronic database containing children's immunization records, though they are not permitted to write to the database.

School-based Health Centers provide more extensive direct services, and differ from the traditional school nurse/health suite services in several ways. They are covered entities under HIPAA if they electronically submit student health data. Their records of health encounters are not included in a student's education record.

Chairman Basch thanked Ms. Mazyck for her presentation, noting that a key element in this issue, as it relates to the use of electronic health records, is the ability to ensure coordination of care. The Chairman said that the Task Force will need to identify specific policy questions for exploration at a later date.

In response to questions from members of the Task Force regarding access to records maintained on students served by school-based health centers, Ms. Mazyck replied that these records are subject to the HIPAA rules for electronic transactions, the primary link being between the school-based health center and primary care providers. In matters regarding a student's complex health status, communication occurs between the primary care physician and the school nurse. Ms. Mazyck observed that a coordinated health record would be a valuable, practical tool in student health care. There is a growing movement in Maryland local school systems to store information electronically, and about half of the 24 systems have this capability. When health records are transferred to a new school, the transfer is from nurse to nurse and is confidential, with the exception of the immunization record.

Based on this initial consideration of the issues raised by school health services for the privacy of the resulting medical records, the Task Force increased its understanding of the enabling statute's mandate to include school health services in its study of electronic health records, and the impact of expanding their use. Key presentation points include:

- A growing number of students in Maryland's schools have serious chronic health conditions, and many receive care for these illnesses in the schools, generating medical records subject to different legal protections and varying degrees of protection against disclosure;
- Coordination of care – whether primary care, emergency medical treatment, behavioral health interventions, or chronic disease management -- between the school health service providers and primary and emergency care providers in the community is essential, and requires a high degree of what is usually privileged communication;
- Neither FERPA nor HIPAA would block an appropriately authorized request for information from a system of electronic health information exchange; and
- The extent and nature of school health records – particularly those from a school-based health center – make them an important part of a student's personal health history.

Chairman Basch suggested that some of the Task Force members might conduct site visits to school-based health centers, to see first-hand how they work. He thanked Ms. Mazyck for sharing her expertise with the Task Force.

IV. Presentation and Discussion — Avalere Health, *Evolution of State Health Information Exchange*

Shanna Koss and Sheera Rosenfeld of Avalere Health gave a presentation on *The Changing Landscape of Health Information Exchange: State and Community Based Activity*, based on a report commissioned by the Agency for Health Research and Quality (AHRQ) on the roles played by various states in developing state health information exchange (HIE) initiatives. Key presentation points include:

- Improvements in access to more timely and accurate health information will benefit many stakeholders, improve health care quality, and reduce spending;
- Numerous initiatives to speed the exchange of automated, clinical, financial, and administrative health care data are underway at the federal, state, and local levels;
- State-based initiatives have not received the same attention as federally and industry sponsored HIE activities, but state involvement is growing.

AHRQ commissioned Avalere to report on the broad landscape of state HIE activities, with an emphasis on identifying trends and best practices. Its environmental scan canvassed a wide array of public information on state-based HIE activity, including 101 projects in 35 states. A cross-section of state initiatives featured eight case studies with a range of selection criteria – including characterizing whether state efforts were “progressive,” “innovative,” “replicable,” “geographically diverse,” and included “unique target populations.” It described state projects in Arizona, Florida, Hawaii, New York, North Carolina, Rhode Island, Tennessee, and Utah. The Avalere report also concluded that:

- No two state HIE projects are alike;
- Initiatives are in a “nascent, formative” state of growth and development;
- States play a significant role as catalyst/convener;
- Advancing HIE is a clear federal priority, but local implementation is likely to be challenging;
- Broad stakeholder involvement is an early priority for many projects;
- Stakeholder representation is varied, yet often extensive;
- Consumer involvement is mixed;
- There is an expressed need for a “clear value proposition with early wins”;
- Tension exists between HIE promotion and quality measurement;
- Sustainability is the long-term, but elusive, goal
- HIE initiatives are using a variety of technology and infrastructure to link care settings;
- Electronic health records are a major component in many HIE initiatives;
- The use of electronic health information exchange is rapidly advancing, and growing both from the top down, and from the bottom up;
- States looking to HIT as a tool to improve quality and manage costs;

- Electronic health records projects include important new technology being considered nationwide;
- There are many roles that states can play to support planning/implementation of HIE initiatives—Medicaid is involved, but in a limited way;
- Focus on HIE and RHIO implementation will continue—many initiatives in any given state;
- Early involvement provides opportunities: influence data points, quality goals, and priorities;
- Continued dialogue, shared learning on challenges, roles, and opportunities will be critical to evolving state leadership.

V. Workgroup Sessions

Debbie Pierce, with the Baltimore region of the Veterans Administration Health System, demonstrated the clinical informatics and the Physician Order Entry system used at Veterans Hospitals nationwide to members of the Computerized Prescribing Workgroup.

VI. Closing Remarks by the Chair

Dr. Basch asked if there were any public members wishing to comment. There were no comments. He announced that the next meeting of the Task Force would be July 10, 2006 at 3:00 p.m., and adjourned the meeting at 4:57 p.m.